

1 To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03542

CERTIFICATE OF DEATH

03532

1. PLACE OF DEATH a. COUNTY Calvert		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick.		b. COUNTY Calver				
c. LENGTH OF STAY IN 1b 2 1/2 wks.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lusby				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital		d. STREET ADDRESS 04-1				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Melinda S. Bafford		First Melinda	Middle S.			
4. DATE OF DEATH March 24	Month March	Day 24	Year 1966			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DATE OF BIRTH January 4, 1922	8. DIVORCED <input type="checkbox"/> MARCH 1966			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home				
11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Jesse Holesapple		14. MOTHER'S MAIDEN NAME Sarah Ette Foster				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 233-52-9110	17. INFORMANT Address Wilson J. Bafford, Lusby, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis. Cardio-Vascular Accident						
4201 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____						
DUE TO (b) _____ (c) _____						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 5 A	20f. (City or town) Lusby	(County) Calvert	(State) Md.
21. I certify that (I) (this hospital) attended the deceased from March 6 , 1966, to March 24 , 1966, that (I) (we) last saw the deceased alive on March 24 , 1966, and that death occurred at 5 A M, from the causes and on the date stated above.						
22a. SIGNATURE <i>Calvert Co.</i>		22b. DATE SIGNED 3/24/66				
22c. PHYSICIAN'S NAME (Type) Issam El Damalouji, M. D.		22d. ADDRESS Prince Frederick, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial March 26, 1966		23b. DATE THEREOF March 26, 1966	23c. NAME OF CEMETERY OR CREMATORIUM St. Paul's Cemetery	23d. LOCATION (City, town or county) (State) Lusby, Calvert, Md.		
24. FUNERAL DIRECTOR A. A. Hartman & Son		25a. REC'D BY REGISTRAR Post Republic, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge		
25c. ADDRESS Mt. St. Pauls Cemetery, Post Republic, Md.		25d. DATE MAR 28 1966				

1 M
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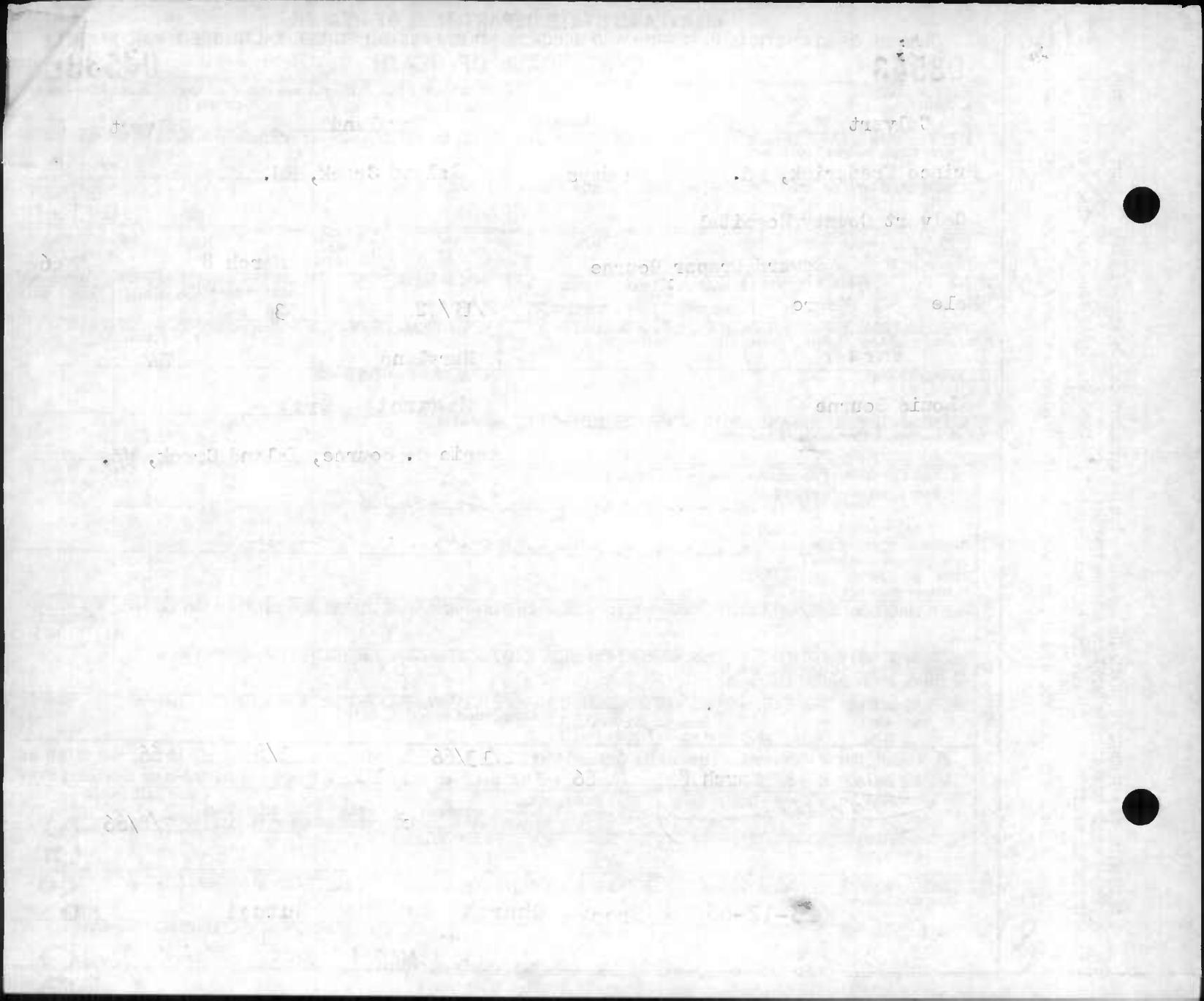
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03543

CERTIFICATE OF DEATH

03533

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick, Md.		c. LENGTH OF STAY IN 1b 21 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital		d. STREET ADDRESS Island Creek, Md.	
3. NAME OF DECEASED (Type or print) Edward Draper Bourne		First Edward	Middle Draper
4. DATE OF DEATH March 8 1966	Month March	Day 8	Year 1966
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 2/13/72
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis Bourne		14. MOTHER'S MAIDEN NAME Magaret Gray	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address Annie R. Bourne, Island Creek, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Coronary occlusion - Generally arteriosclerosis -		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from 2/13/66 , 19 66 , to 3/8 , 19 66 , that (I) (we) last saw the deceased alive on March 8 19 66 , and that death occurred at TOP M, from the causes and on the date stated above.		22b. DATE SIGNED 3/8/66	
22a. SIGNATURE W. Williams		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS
22c. PHYSICIAN'S NAME (Type)			
23a. BURIAL, CREMATION, REMOVAL (Specify) 3-12-66		23b. DATE THEREOF 3-12-66	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Brooks Church Cem
24. FUNERAL DIRECTOR Linkney E. Sevell - Prince Frederick		25a. REC'D BY REGISTRAR Mar 11 1966	25b. REGISTRAR'S SIGNATURE Charles Judge
VR A15 (4) 15M 4-64			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03534

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> <i>MARYLAND</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write PM4 and give nearest town) <i>Huntingtown</i>		c. CITY OR TOWN (If outside corporate limits, write PM4 and give nearest town) <i>Huntingtown</i> 04-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Minnie M</i>	Middle <i>Chase</i>	Last
4. DATE OF DEATH	3	Month	Day
	1966	Year	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1
9. AGE (In years last birthday) 85 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>W</i>	11. BIRTHPLACE (State or foreign country) <i>Md</i>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>James Ward</i>	14. MOTHER'S MAIDEN NAME ?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or question) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Eugene Chase Huntingtown</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Cardio vascular, renal disease age 60 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Had been bedridden 10 yrs</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> <i>Actual Signature: H. Ward</i>			
ACTUAL SIGNATURE	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type)	DATE SIGNED <i>3/27/68</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>3-31-68</i>	22b. DATE THEREOF <i>3-31-68</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Youngs Church Cem</i>	22d. LOCATION (City, town, or county) (State) <i>Huntingtown Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Linen E. Seawell - Prince Fred, Md</i>	ADDRESS	24a. REC'D BY REGISTRAR <i>MAR 30 1966</i>	24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1 M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03545 113535

1. PLACE OF DEATH

a. COUNTY

Calvert

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Prince Frederick (rural)

c. LENGTH OF STAY IN 1b

life

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Prince Frederick (rural)

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

Md

b. COUNTY

Calvert

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Prince Frederick (rural)

d. STREET ADDRESS

04-1

e. IS RESIDENCE
ON A FARM?

YES ND

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

March

25 1966

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED

NEVER MARRIED

WIDOWED

8. DATE OF BIRTH

May 29 1901

64

yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Farm

10b. KIND OF BUSINESS OR
INDUSTRY

Farming

11. BIRTHPLACE (County & State, or foreign country)

Calvert Co. Md.

12. CITIZEN OF WHAT
COUNTRY?

U.S.A.

13. FATHER'S NAME

James E. Conner

14. MOTHER'S MAIDEN NAME

Ella W. Hutchins

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

216-18-5401

17. INFORMANT

Harry Conner - Prince Frederick Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4201

DUE TO

Conditions, If any, which
gave rise to Immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO

(c)

Cardiac Failure (Cereosclerotic)

INTERVAL BETWEEN
DISEASE AND DEATH

2 years

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 19

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from September 1966 to March 25, 1966, that (I) (we) last
saw the deceased alive on March 23, 1966, and that death occurred at 8a M, from the causes and on the date stated above.

22a. SIGNATURE

Jesse Jett

22b. DATE SIGNED

22c. PHYSICIAN'S
NAME (Type)

Page C. Jett

M.D. ATTENDING
PHYS. MED.
DIRECTOR STAFF
PHYS.

22d. ADDRESS

Prince Frederick, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

Mar. 27, 1966

23c. NAME OF CEMETERY OR CREMATORIUM

Rosbury Cemetery

23d. LOCATION (City, town or county) (State)

Bethel Calvert Co. Md.

24. FUNERAL DIRECTOR

A. A. Harkness Son

Post Republic, Maryland

ADDRESS

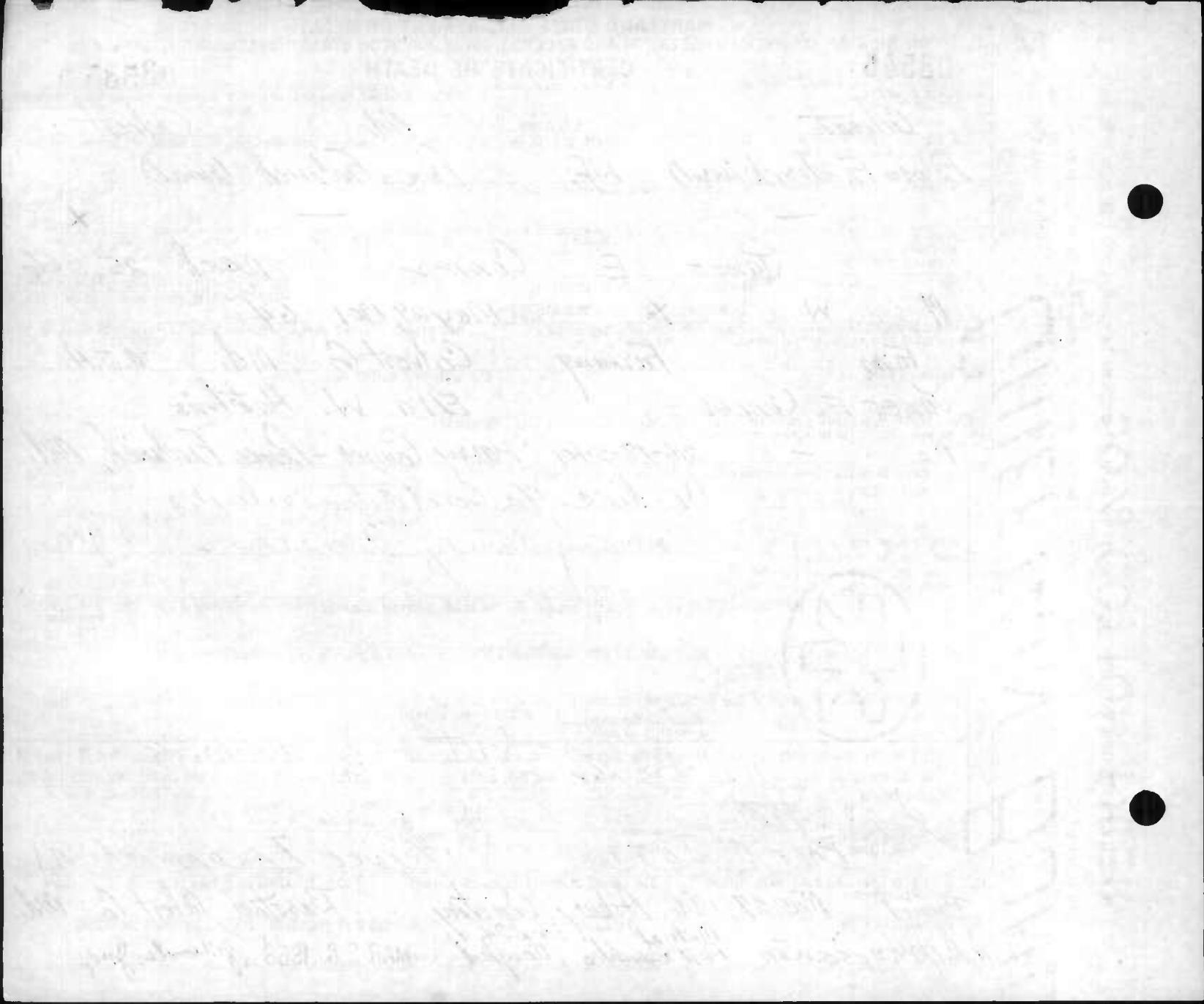
Box 34

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE MAR 28 1966

Charles Judge



1 M
FOR STATE
HEALTH DEPT.

03546

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03536

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pen, on item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mutual		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) King's Tavern		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WALTER	First V.	Middle .	Last CURTIS
4. DATE OF DEATH March 19 1966	Month March	Day 19	Year 1966
5. SEX male	6. COLOR OR RACE negro	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED
8. DATE OF BIRTH 5-29-15	9. AGE (In years last birthday) 50 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. BIRTHPLACE (State or foreign country) Labor		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Walter Curtis		14. MOTHER'S MAIDEN NAME Mary Moore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	16. SOCIAL SECURITY NO. 137-12-0528	17. INFORMANT Louise Curtis	Address Port Republic -Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 983+ Massive subarachnoid hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rupture of thin walled artery at base of brain. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 2Dc. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 2Dc. TIME OF INJURY Month, Day, Year Hour <input checked="" type="checkbox"/> p.m. 3/19 1966			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Involved in altercation		2Dc. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) Tavern	
2Dc. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) Tavern		2Df. (City or town) (County) (State) Island Creek Calvert Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty	CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		22. DATE SIGNED 3/20/66
EXAMINER'S NAME (Type) Charles S. Petty	ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)
23a. BURIAL, CREMATION, REMOVAL (Specify) Mutual	23b. DATE THEREOF 3-24-66	23c. NAME OF CEMETERY OR CREMATORIAL Brooks Church Cem	23d. LOCATION (City or Town) (County) (State) Calvert Md
24. FUNERAL DIRECTOR Linkney E. Sewell Prince Frederick, Md	ADDRESS	25a. REC'D BY REGISTRAR MAR 23 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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03547

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03537

M

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dunkirk		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Friendship	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)		First JOSEPH	Middle JOHN	Last GIBSON	4. DATE OF DEATH March 28	Month	Day	Year 19 66
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5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1896	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Calvert Co., Maryland	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME Joseph J. Gibson	14. MOTHER'S MAIDEN NAME Hettie Trott
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. WWI	17. INFORMANT 217-36-6827 Mrs. Charlotte Lewis, Friendship, Maryland	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cardiac failure		15 min.
7824 DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)		
DUE TO		
(c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). WAS AUTOPSY PERFORMED? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Dropped dead at home while hardly talking	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. 7:45 a. Mar. 28 1966	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .				
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ACTUAL SIGNATURE <i>H. W. Ward</i>		DATE SIGNED 3/29/66
EXAMINER'S NAME (Type) H. W. Ward	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 30, 1966	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mt. Harmony Chr. Cemetery	22d. LOCATION (City, town, or county) (State) Owings, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hitchins Funeral Home, Owings Md.</i>		24a. RECD BY REGISTRAR MAR 31 1966	24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

RECENT EXAMINATIONS OF DEATH

1 To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

2 Page 4 may be retained by the hospital or attending physician.

3 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

M

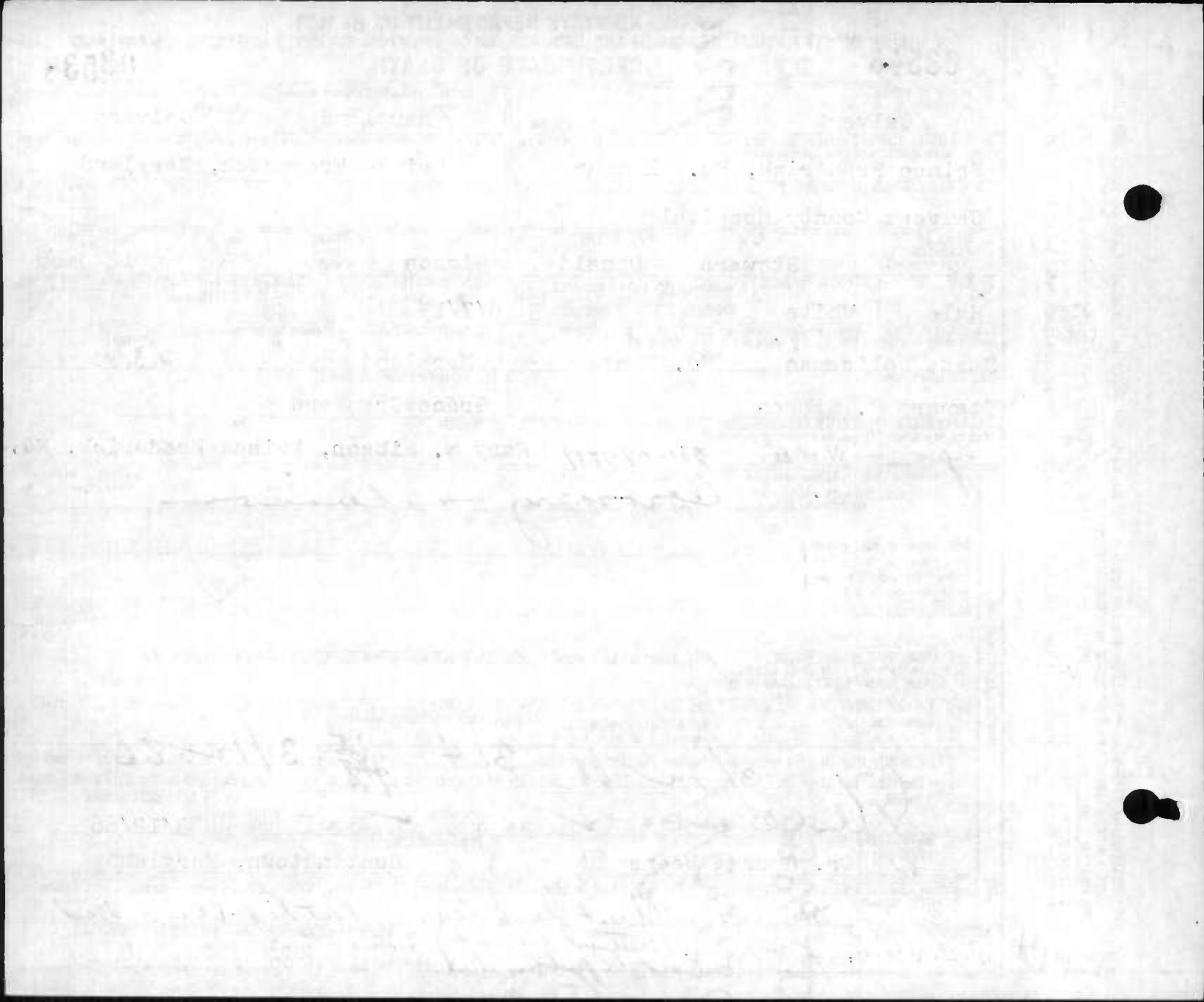
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03548

CERTIFICATE OF DEATH

03538

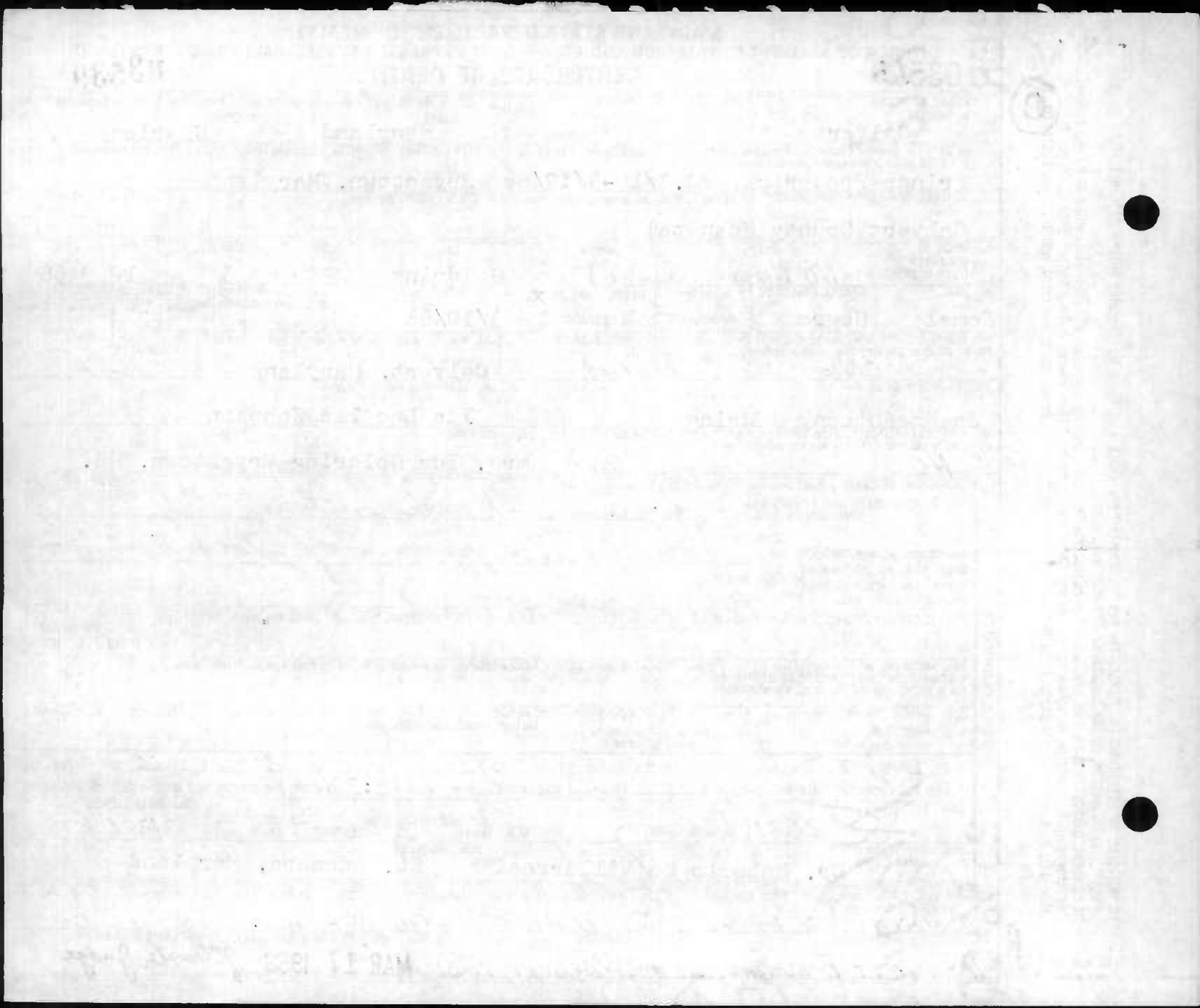
1. PLACE OF DEATH a. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick, Md.		c. LENGTH OF STAY IN 1b 1 hour	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital		e. IS RESIDENCE DN A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
59		04-1	
3. NAME OF DECEASED (Type or print)	First Stewart	Middle Donald	Last Gibson
4. DATE OF DEATH	3	Month	Day 12
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8/7/15
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 50 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) State Policeman		10b. KIND OF BUSINESS OR INDUSTRY Md. State	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stewart C. Gibson		14. MOTHER'S MAIDEN NAME Grace Cranford	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 220-07-1909 17. INFORMANT Address Mary W. Gibson, Prince Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201		INTERVAL BETWEEN ONSET AND DEATH Coronary occlusion	
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO			
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED p.m. 19 While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/4, 1966, to 3/12, 1966, that (I) (we) last saw the deceased alive on 3/12, 1966, and that death occurred at 97 M, from the causes and on the date stated above.		22b. DATE SIGNED 3/12/66	
22a. SIGNATURE Weems		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 3/12/66	
22c. PHYSICIAN'S NAME (Type) Dr. George Weems		22d. ADDRESS Huntingtown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 15, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL Christ Church Cem.		23d. LOCATION (City, town or county) Port Republic, Md	
24. FUNERAL DIRECTOR G. A. Hackney & Son		25a. ADDRESS Municipal Bldg 34	
		25a. REC'D BY REGISTRAR MAR 15 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																							
CERTIFICATE OF DEATH																							
1. PLACE OF DEATH a. COUNTY Calvert MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles																			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick, Md.				c. LENGTH OF STAY IN 1b 3/10-3/12/66																			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
3. NAME OF DECEASED (Type or print)		First (No Name Given)	Middle	Last	4. DATE OF DEATH	Month	Day	Year															
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.																
Female		Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	3/10/66	Yrs. 2	Months 2	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (County & State, or foreign country) Calvert, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME James Anthony Goldring												14. MOTHER'S MAIDEN NAME Ida Lucille Johnson											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address											
NO				NONE				Mrs. Ida Goldring				Bryantown, Md.											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7615												<i>Depression, failure due to Respiratory, Respiratory, pleurisy, 2 hours</i>											
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.				DUE TO (b) <i>Respiratory</i>				DUE TO (c) <i>cardiac</i>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 3/10 , 1966, to 3/12 , 1966, that (I) (we) last saw the deceased alive on 3/12 , 1966, and that death occurred at 5:30 A.M. from the causes and on the date stated above.												22b. DATE SIGNED 3/12/66											
22a. SIGNATURE <i>Dr. Roberto De Villarreal</i>												22b. ADDRESS St. Leonard, Maryland											
22c. PHYSICIAN'S NAME (Type)				23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL								23b. DATE THEREOF 3-13-66				23c. NAME OF CEMETERY OR CREMATORIAL ST MARY'S Cem.				23d. LOCATION (City, town or county) (State) BRYANTOWN, MD.			
24. FUNERAL DIRECTOR The Hunt Funeral Home, WALDORF, MD.												25a. REC'D BY REGISTRAR MAR 17 1966				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							
6-11-1																							



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

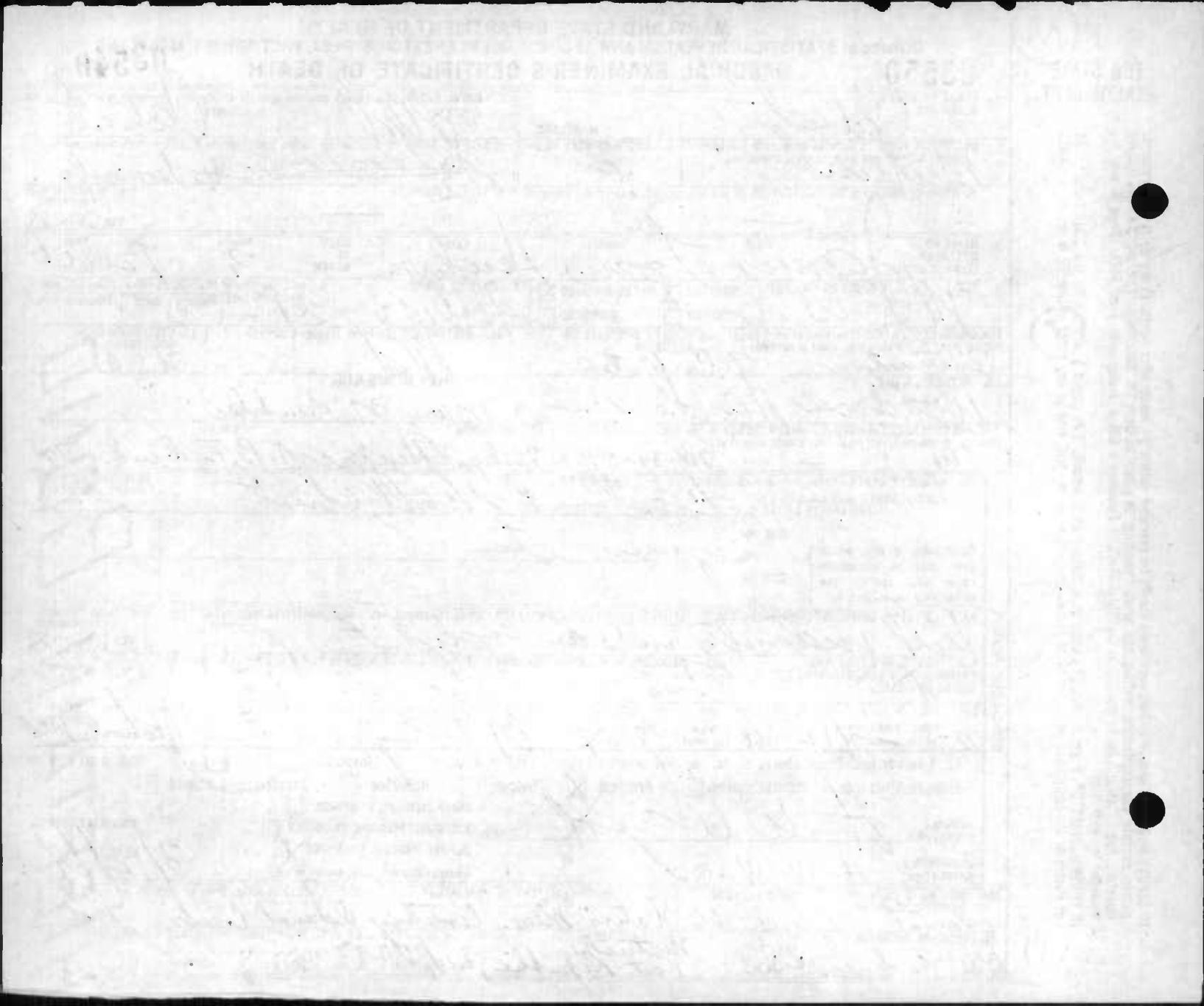
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03550 035540

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Maryland</i>		c. LENGTH OF STAY IN 1b <i>1 week</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>None</i>		d. STREET ADDRESS <i>St. Leonard</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		04-1	
3. NAME OF DECEASED (Type or print)	First <i>James</i>	Middle <i>Louis</i>	Last <i>Henderson</i>
4. DATE OF DEATH Year <i>3/12/66</i>	Month <i>3</i>	Day <i>12</i>	Year <i>66</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/26/36</i>
9. AGE (In years last birthday) <i>29</i>	10. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>	11. BIRTHPLACE (State or foreign country) <i>Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Woodrow Henderson</i>	14. MOTHER'S MAIDEN NAME <i>Mary N. Buckley</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>218-34-5902</i>		17. INFORMANT <i>Evelyn Henderson - P. F. Fabrick, wd</i>	Address <i>101 N. Franklin, Chestertown, Md.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) <i>8/6/4</i>		DUE TO <i>Respiratory arrest, chest</i>	
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause, last. <i>Conditions etc</i>		(b) <i>ignis etc</i>	
DUE TO <i>at work</i>		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Fell suddenly in bed asleep</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>Two car collision</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>Two car collision</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>12:30 3/12 1966</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office building, etc.) <i>204 1/2 Bay Street, Calvert, Md.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. ACTUAL SIGNATURE <i>H. W. Ward</i>	
22. DATE SIGNED <i>3/12/66</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Mar. 14, 1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Ward's Mem. Cemetery, Calvert Creek, Md.</i>
24. FUNERAL DIRECTOR <i>G. A. Hackney & Son -</i>		25a. ADDRESS <i>Port Republic, Md.</i>	25b. REC'D BY REGISTRAR DATE <i>Mar 15 1966</i>
		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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03551

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03541

1. PLACE OF DEATH a. COUNTY Calvert		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville		d. STREET ADDRESS 108-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CALVERT COUNTY HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First ALICE	Middle JONES	4. DATE OF DEATH March 14 1966	Month March	Day 14	Year 1966
S. SEX Female	6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-4-1921	9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Prince George's Co.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph Greenfield Wills		14. MOTHER'S MAIDEN NAME Agnes Washington					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Robert Jones-Hughesville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Myocardial Ischemia occurring during				INTERVAL BETWEEN ONSET AND DEATH	
633+ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) hysterectomy.					
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Obesity, Anemia, Myocardial Hypertrophy.						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Petty		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 3-15-66	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-18-66		23c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Church Cem.		23d. LOCATION (City or Town) (County) (State) Bryantown, Md.	
24. FUNERAL DIRECTOR Martell Adams		ADDRESS Aquasco, Maryland		25a. REC'D BY REGISTRAR MAR 21 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03552

CERTIFICATE OF DEATH

03542

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and an event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Calvert		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick, Md.		b. COUNTY Calvert	
c. LENGTH OF STAY IN 1b 3/17-3/20/66		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Beach, Maryland 04-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Male Arthur Coburn Leannarda		4. DATE OF DEATH 3 20 1966	Month Day Year
5. SEX Male White		6. COLOR OR RACE WIDOWED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH 6/5/85		9. AGE (in years last birthday) 80 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Sanitary dep.	11. BIRTHPLACE (County & State, or foreign country) Maryland
13. FATHER'S NAME Charles Walker Leannarda		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) P		16. SOCIAL SECURITY NO. ?	17. INFORMANT Address Margaret Leannarda North Beach, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE 593 X		INTERVAL BETWEEN ONSET AND DEATH Malaria - 14 days	
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-17-1966 to 3-20-1966, that (I) (we) last saw the deceased alive on 3-20-1966, and that death occurred at 10:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Dr. Issam F. el Damalouji</i>		22b. DATE SIGNED M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 3/21/66	
22c. PHYSICIAN'S NAME (Type) Dr. Issam F. el Damalouji		22d. ADDRESS Prince Frederick, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-land		23b. DATE THEREOF 3/21/66	23c. NAME OF CEMETERY OR CREMATORIAL Calvary Mem. Park
24. FUNERAL DIRECTOR O. A. Harkness & Son		25a. ADDRESS Mutual Roy 34 Port Republic, Md.	25b. LOCATION (City, town or county) Tunisia, Va
		25a. REC'D BY REGISTRAR MAR 23 1956	25b. REGISTRAR'S SIGNATURE Charles Judge

SEG 30

521 2-100
200's South

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03553 03543

1. PLACE OF DEATH a. COUNTY		Information from		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		b. STATE			
<i>Calvert</i>				<i>Calvert</i>		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1B		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS			
<i>W. Beach</i>		MARYLAND		<i>W. Beach</i>		<i>W. Beach</i> MD 04-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
00									
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month	Dey	Year		
<i>Raymond Clarence Long</i>				<i>Dec 10 1965</i>	3	6	1966		
5. SEX		6. COLOR OR RACE	7. MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
<i>M</i>			<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	<i>Dec 10 1965</i>	3 yrs.	<i>Mc</i>	<i>Mc</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
<i>Raymond C Long</i>									
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
<i>Raymond C Long</i>		<i>Ruby Virginia Hunter</i>		<i>Yes</i>		<i>1630 11th St</i>		<i>Address</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]		19. INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)		<i>Bacmonia & Malaria</i>							
492 X Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (b)	<i>Cold & worms</i>						
		DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
<i>Found dead in bed at 6:30 AM</i>									
20c. TIME OF INJURY Month, Day, Year Hour a.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)			
<i>6:30 AM 31 Dec 1966</i>		<i>Not While at work</i>	<i>Home</i>	<i>W. Beach</i>	<i>Calvert</i>	<i>MD</i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED			
<i>H. W. Ward</i>						<i>3/6/66</i>			
ACTUAL SIGNATURE		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town or county)					
EXAMINER'S NAME (Type)									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION (City, town or county)	(State)				
<i>Burial</i>		<i>3-7-66</i>	<i>Mt. Hope church cem. Sunderland, Md.</i>	<i>Sunderland, Md.</i>					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE				
<i>Leroy Berry Huntington</i>		<i>MD</i>		<i>Mar 8 1966</i>	<i>Charles Judge</i>				

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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M

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)									
a. COUNTY Calvert				a. STATE Md. b. COUNTY Charles									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pr. Fred.				c. LENGTH OF STAY IN 1b 1 month									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert Nursing Home				d. STREET ADDRESS STAR CT. # 2									
3. NAME OF DECEASED (Type or print)	First Joseph	Middle J. S.	Last Sidler	4. DATE OF DEATH March 6 1966	Month March	Day 6	Year 1966	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-22-1886	9. AGE (In years last birthday) 79 yrs.	10. KIND OF BUSINESS OR INDUSTRY HW	11. BIRTHPLACE (County & State, or foreign country) Wajemoy, Md	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME JOSEPH JOHNSON	14. MOTHER'S MAIDEN NAME HANNA POSEY	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Milton Sidler, WALDORF, MD	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Coronary Occlusion (c) Arteriosclerotic CV disease													
INTERVAL BETWEEN ONSET AND DEATH 5 seconds													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Chronic colitis													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY		Month, Day, Year	Hour a.m. p.m.	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)					
19				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
21. I certify that (I) (this hospital) attended the deceased from 2/9 , 1966, to 5/6 , 1966, that (I) (we) last saw the deceased alive on 3/6 , 1966, and that death occurred at 112 M , from the causes and on the date stated above.													
22a. SIGNATURE Joseph Sidler													
22b. DATE SIGNED 3/6/66													
22c. PHYSICIAN'S NAME (Type) JOSEPH C. JETT				22d. ADDRESS PRINCE FREDERICK									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-9-66		23c. NAME OF CEMETERY OR CREMATORIAL Wajemoy Baptist				23d. LOCATION (City, town or county) (State) Wajemoy, MD.					
24. FUNERAL DIRECTOR AREHART FUNERAL HOME INC.		ADDRESS LAPLATA, MD.		25a. REC'D BY REGISTRAR MAR 14 1966		25b. REGISTRAR'S SIGNATURE Charles Judge							
VR A15 (4) 20M 1/65													

YESTERDAY

FOODS EATEN

DRINKS DRUNK

WEATHER

1
M
FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

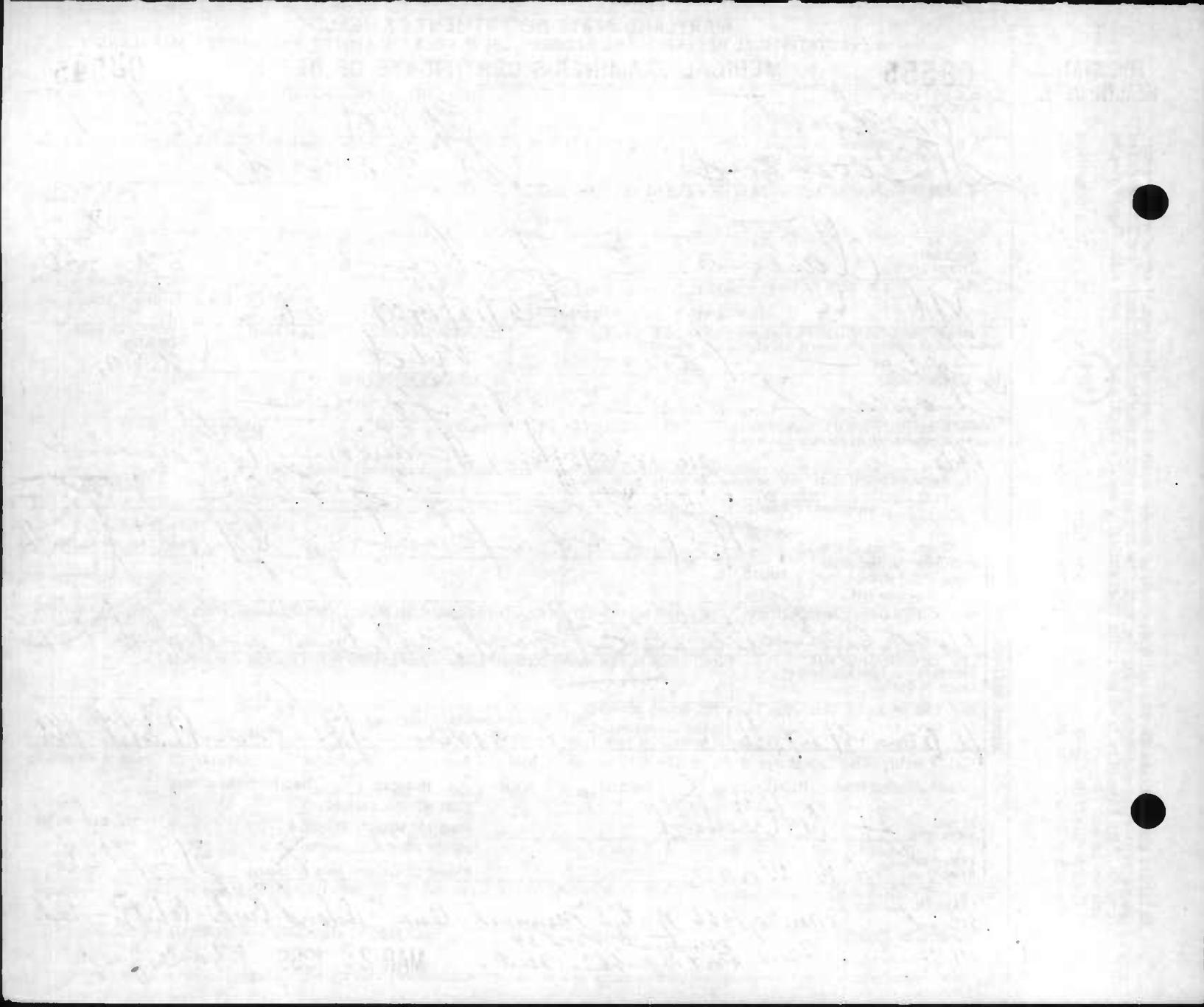
To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03555 03545

1. PLACE OF DEATH a. COUNTY <i>Bel Air</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bel Air</i>		c. LENGTH OF STAY IN 1b <i>Leonards</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>—</i>		d. STREET ADDRESS <i>Leonards</i>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		04-1	
3. NAME OF DECEASED (Type or print) <i>Clarence E. Justice</i>		First	Middle
4. DATE OF DEATH 3 27 1966		Last	Month Day Year
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. KIND OF BUSINESS OR INDUSTRY <i>Farmer</i>		9. DATE OF BIRTH <i>5/15/1909</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		9. AGE (in years last birthday) <i>56 yrs.</i>	
10b. BIRTHPLACE (State or foreign country) <i>Md</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		12. MOTHER'S MAIDEN NAME <i>Zoeller</i>	
13. FATHER'S NAME <i>Thomas Justice</i>		14. ADDRESS <i>John Henderson Leonard</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. 17. INFORMANT <i>216-18-5424 John Henderson Leonard</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <i>7824</i>		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
DUE TO (b) Conditions, If any, which gave rise to immediate cause (e), stating the underlying cause last. <i>Had had a fall & left wrist pain 2 1/2</i>		20. TIME OF INJURY Month, Day, Year 10:00 a.m. 3/27/66	
DUE TO (c)		20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home Leonard Leonard Md</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Had fallen breakfast and sat down and died</i>		20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20d. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 1b.) <i>—</i>		20e. (City or town) (County) (State) <i>(None)</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>H. W. Ward</i>		22. DATE SIGNED <i>3/27/66</i>	
EXAMINER'S NAME (Type) <i>H. W. WARD</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>(None)</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Mar. 30, 1966</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Walt's Memorial</i>		23d. LOCATION (City, town or county) <i>Island Creek - Calvert Co. - Md.</i>	
24. FUNERAL DIRECTOR <i>G. A. Hackman & Son</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. DATE <i>MAR 29 1966</i>	



1 To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, at any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												03546		
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)			a. STATE			b. COUNTY					
Calvert MARYLAND			Maryland			Calvert								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?		
Prince Frederick, Md			1/22-3/12/66			Chesapeake Beach, Maryland			Chesapeake Beach, Md.			YES <input type="checkbox"/> NO <input type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)														
Calvert County Hospital														
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year						
Leroy				Woods	3	12	19	66						
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS							
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7/3/73	92 yrs.	Months	Days	Hours						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?					
Hotel Owner - Retired			Hotel			Tennessee			USA					
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME											
John L. Woods			Elizabeth Wallace											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address					
No			578-18-9710			Eva Curtis Woods			Chesapeake Beach, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]														
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)														
4200 Circulatory Collapse Arteriosclerotic Heart Disease.														
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.														
DUE TO (b) DUE TO (c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 1/19/63, 19, to 3/11, 1966, that (I) (we) last saw the deceased alive on 3/11, 1966, and that death occurred at 11:15 A.M. from the causes and on the date stated above.														
22a. SIGNATURE									22b. DATE SIGNED					
Oz. Ersoy									3/12/66					
22c. PHYSICIAN'S NAME (Type)			M.D. ATTENDING PHYS.			M.E. DIRECTOR			STAFF PHYS.					
Dr. O.Z. Ersoy			<input checked="" type="checkbox"/>			<input type="checkbox"/>			<input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City, town or county) (State)					
Burial			3/15/66			National Memorial Park			Falls Church Virginia					
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Robert J. Murphy						MAR 18 1966			Charles Judge					

